

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010990

STATE FILE NUMBER

Registration District No. 2155

FILED MAR 25 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4496 Maryland Ave		d. STREET ADDRESS (If outside, give location) 4496 Maryland Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last MAY ELIZABETH HARRIS		4. DATE OF DEATH Month Day Year March 8, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1874
9. AGE (In years) 84 (last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME David A. Covington		13b. MOTHER'S MAIDEN NAME Ellen Morgan	
14. NAME OF HUSBAND OR WIFE Henry P. Harris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Ella Willis- 322 N. Brentwood Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>myocardial hypertrophy with</u> DUE TO (c) <u>decompensation 422.2</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 MTH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION COUNTY STATE		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 11 AM on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from Death occurred at 11 AM on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Fred Krammer M.D.		22b. ADDRESS 4161 Lunsell	
22c. DATE SIGNED 3-9-59		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 11, 1959	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.		23d. LOCATION (City, town, or county) (State) Kirkwood 22, Mo	
24. FUNERAL DIRECTOR Pfitzinger Mort-Kirkwood 22, Mo.		25. DATE RECD. BY LOCAL REG. MAR 10 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Ben C. Hoffman

Licensed Embalmer No.

P. O. Address,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.